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Medicare Modernization Law: Roadmap to Reform

Introduction

Despite recent, dramatic advances in pharmaceutical care – and the private health insurance system's long-standing acknowledgment that prescription-drug coverage is a cost-effective alternative to hospitalization – the Medicare program has not included most prescription-drug benefits outside of the hospital setting. With President Bush's signature on the Medicare modernization bill in December, Medicare beneficiaries now will be provided a prescription-drug benefit.[1]

The addition of a prescription drug benefit was just one of the goals for Medicare. Republicans had other goals, designed to update Medicare's benefit structure and strengthen the program generally. Republicans' basic goals were:

1) Provide a voluntary prescription drug benefit;

2) Reduce the rising cost of prescription drugs;

3) Expand the number of health care choices available to seniors;

4) Improve the quality of care delivered by the Medicare program; and

5) Reform the program to assure fiscal soundness.

This paper reflects on the relative success achieved in meeting these goals. Complete success was tempered by the fact that the new law is the result of substantial compromise. Even so, most Republicans can agree that much was achieved.

Both liberal and conservative policymakers undoubtedly will attempt to further reshape the Medicare program. When that debate begins, Republicans will need both to protect and expand important and hard-won reforms.

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[1] "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" [P.L. 108-173, signed on December 8, 2003].

Goal #1: Providing a Prescription Drug Benefit

Three-quarters of today's Medicare beneficiaries receive prescription-drug coverage in varying degrees through an array of programs, such as employer-based plans (31.7 percent), Medicaid (12.3 percent), Medicare + Choice (17.1 percent), Medigap coverage (12.8 percent), the Department of Veterans Affairs, Department of Defense, and other state pharmaceutical programs (5.3 percent).[2] Thus, nearly 25 percent of Medicare beneficiaries last year were without any form of prescription-drug coverage. Many Republicans advocated concentrating on individuals with insufficient or no coverage – a premise that arguably could have produced better results. However, because a decision was made early in the debate to provide a universal benefit to all seniors, this meant less money would be available for the most needy, and employers would need an incentive to retain retiree drug-coverage benefits.[3]

The new drug coverage, beginning in 2006, provides seniors with the following options:

- Beneficiaries in traditional fee-for-service Medicare may voluntarily enroll in a Prescription Drug Plan, also referred to as a PDP. PDPs are *private plans* that would contract with Medicare to provide drug coverage as part of traditional Medicare.

- Alternatively, beneficiaries may choose to enroll in a new "Medicare Advantage" plan (a local health maintenance organization (HMO) or preferred provider organization (PPO)) that offers drug coverage in addition to all other Medicare benefits.[4]
- Some beneficiaries also could receive prescription-drug coverage through a former employer, just as they do currently. Medicare will assist that employer in paying for such coverage. In addition, an employer may choose to offer additional coverage via a Medicare PDP.

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[2]Medicare Current Beneficiary Survey, Centers for Medicare and Medicaid, 2000.

[3]The Congressional Budget Office estimates that the employer assistance will increase federal spending by $89 billion over 10 years. Employers could receive a 28-percent federal subsidy, excluded from taxation, if they offer coverage that is of equal value to the Medicare benefit for any drug costs between $250 and $5,000. Almost 32 percent of today's seniors receive drug coverage under an employer-based plan. Recent trends, however, suggest that employer-provided coverage is eroding. According the Department of Health and Human Services, "approximately 66 percent of large firms (200+ workers) offered retiree health benefits in 1988. By 2003, coverage had declined to only 38 percent of large firms." "Medicare Beneficiaries' Employer Sponsored Drug Coverage," Fact Sheet, Department of Health and Human Services, November 2003.

[4]According to the Centers for Medicare and Medicaid Services, PPOs are a growing form of health insurance and the most popular type of coverage in the private market. PPO enrollees can go to any provider and receive reimbursement for services rendered. However, the amount of payment depends on whether the provider is "in or out" of the PPO network. Additionally, PPOs may agree to file claims on behalf of enrollees, participate in quality improvement projects, and offer a wider range of benefits and services than fee-for-service arrangements.

- Finally, beneficiaries have the option to retain current Medigap prescription drug policies rather than enroll under the new Medicare Part D program. However, renewing these supplemental drug polices likely will be a more expensive option for the vast majority of beneficiaries.

Goal #2: Reducing the Cost of Prescription Drugs

According to the Centers for Medicare and Medicaid Services, "Prescription drugs are the fastest-growing segment of overall national health expenditures."[5] As a result, the new law aims to reduce rising costs for Medicare beneficiaries in particular, and for all Americans in general.

The first opportunity for savings starts in June of this year when a prescription drug discount card will become available, providing prescription-drug savings of 10 percent to 25 percent. Lower-income seniors will receive an additional $600 per year in assistance on top of these discounts.

Second, the law injects competition into the Medicare marketplace, which also will help drive down the price of drugs. Private health plans have been largely successful in negotiating discounts with pharmaceutical manufacturers. The Congressional Budget Office (CBO) assumes that those beneficiaries enrolled in a Medicare PDP or Medicare Advantage program will reap additional savings, since these plans likely would "combine the attributes of an insurance company and a pharmacy benefit manager (PBM)."[6] PBMs were designed in part to negotiate discounts with pharmacies and drug manufacturers on behalf of health plans.

Third, to help Americans of all ages with the challenge of rising drug expenses, the law provides incentives to encourage the use of generic pharmaceuticals, which often are less expensive than brand-name drugs.

Finally, the law strives to reduce long-term costs by evaluating the comparatively high price of drugs in the United States as compared to most other countries.[7] In short, many of today's industrialized countries impose strict price controls on pharmaceuticals, effectively shifting the costs for developing the drugs to U.S. consumers.

The House of Representatives proposed the importation of these price-controlled pharmaceuticals from Canada as a way to reduce the cost of drugs for Americans. This approach was rejected by the

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[5]Centers for Medicare and Medicaid Services, "Health Care Industry Market Update: Pharmaceuticals," January 10, 2003.

[6]Congressional Budget Office Cost Estimate of House and Senate Medicare bills, July 22, 2003.

[7]U.S. International Trade Commission, "Pricing of Prescription Drugs," Investigation No. 332-419, Publication 3333, December 2000, p. 2-2.

Medicare conference committee for two reasons. First, there are serious safety concerns associated with this proposal.[8] As a result, the Medicare bill modifies the 2000 Medicine Equity and Drug Safety (MEDS) Act to permit importation from Canada but requires the Secretary of Health and Human Services to implement safeguards to ensure any imported drug is certified as safe and deemed more cost-effective if imported into the United States.

The second reason House conferees rejected the House proposal was that importation of pharmaceuticals would only treat the symptom, not the cause – which, as was noted earlier, is the imposition of price controls elsewhere. The appropriate response, rather, is for the U.S. Trade Representative to negotiate relief in this area. Current laws, such as the Trade Promotion Authority Act, provide a compelling rationale for the inclusion of pharmaceutical access and pricing in trade negotiations. The new Medicare bill recognizes this concern and, for the first time, encourages our trade representatives to develop a strategy that aims to reduce cost-shifting tactics.

Goal #3: Improving Choices for America's Seniors

A third fundamental goal for Republicans was to provide seniors with a choice of Medicare benefit options. This was to encourage more cost-effective alternatives (with both the beneficiary and the government sharing in the potential savings) to promote better quality care and to acknowledge the inherent value in freedom of choice. The President and others compared this choice-in-benefits approach to the Federal Employees Health Benefit Program (FEHBP), which has existed for over 43 years and currently covers some 9 million federal employees, annuitants, and Members of Congress. It long has been regarded as a model for a 21st Century Medicare program.

The FEHBP contracts with private health plans that specifically offer preventative care, pharmaceutical benefits, and disease management. The program's emphasis on choice, preventative health care, and coordination of benefits has enabled it to keep premium increases to an average of 10.6 percent over the past year as compared to 18 percent nationwide.[9]

The Medicare law partially incorporates some features of the FEHBP model by offering seniors a choice of local health maintenance organizations or regional or local preferred provider organizations. It also provides for an unlimited number of companies that can bid in a region or locality. This is important to allow a maximum choice of health plans. Restricting the number of organizations to two or three bidders, as originally proposed, may help reduce costs–but at the expense of consumer choice. For instance, the

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[8]U.S. Food and Drug Administration, "FDA/U.S. Customs Import Blitz Exams Reveal Hundreds of Potentially Dangerous Imported Drug Shipments," Press Release, September 29, 2003. The "blitz" conducted spot examinations of mail shipments of foreign drugs to U.S. consumers, finding that many shipments contained dangerous, unapproved, or counterfeit drugs that pose potentially serious safety problems.

[9]Office of Personnel Management, "OPM Director Kay Coles James Announces 2004 Federal Employees Health Benefits Program Premiums," Press Release, September 16, 2003.

FEHBP offers enrollees almost 190 benefit options by over 130 health plans. According to the Office of Personnel Management, all members, despite geographic location, have the option to choose from among no fewer than a dozen health plans.[10] Allowing multiple bids will ensure Medicare beneficiaries have access to high-quality benefits.

Despite this improvement, however, there is one remaining obstacle hindering the number of private health plans that may enter the Medicare marketplace. Contrary to the FEHBP, the new law requires that the payment rates be tied to the traditional Medicare program. While this requirement may cut costs in the short run, it does not reflect true market costs. In times past, Congress has misjudged the market and under-reimbursed physicians and hospitals, causing subsequent federal payment adjustments that can be expensive and disruptive. By tying the Medicare Advantage payment rates to the traditional program, Congress may indirectly inhibit the growth of this market. With continued surveillance and commitment toward a market-oriented health care system, it is hoped that Congress can overcome this hurdle.

Goal #4: Ensuring Quality Health Care

As noted above, the fluctuation of Medicare payment rates has caused many hospitals, physicians and other health care providers to reduce or eliminate certain medical services. The new law recognizes the importance of quality of care as a critical component to Medicare modernization by including the following noteworthy payment measures:

- New Medicare funding to address historical payment inequities between rural and urban health care providers, including, but not limited to, equal standardized hospital payment amounts, adjusted labor share hospital payments, and improved rural geographic physician payments.
- Full inflationary update, also referred to as the market basket update, for hospitals submitting scientifically-recognized quality reporting data for common hospital-admitted conditions.
- Increased indirect medical education (IME) payments to help teaching hospitals continue training physicians in state-of-the-art clinical care.
- Temporary payment increases for physician payments in 2004 and 2005, eliminating a scheduled payment cut of 4.5 percent during these years.

In other cases, payments were reduced under the new Medicare law, and it is unclear to what degree these changes will impact individual providers, physicians, or medical suppliers.

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[10]Office of Personnel Management, "Statement of Abby L. Block, Senior Advisor for Employee and Family Support Policy," Testimony before the Special Committee on Aging, United States Senate, May 6, 2003.

Particularly, the law:

- Reduces drug and biological payments purchased by oncologists, rheumatologists, gastroenterologists and other specialty physicians;
- Lowers payments to ambulatory surgical centers;
- Decreases annual inflationary payments for home health care providers; and
- Phases-in competitive bidding requirements for durable medical equipment.

Goal #5: Reforming Medicare and other Cost-Containment Mechanisms

A final Republican goal was to include some form of cost-containment in the new law, given the projected expense of the new drug entitlement, coupled with the program's unsustainable existing commitments for a soon-to-retire Baby Boom generation.[11] The law takes steps in the right direction. However, it is clear much more attention to Medicare costs will be required in the future. To this end, the Medicare law creates a new accounting measure requiring the Medicare Trustees to analyze the combined expenditures and dedicated revenues of the Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund (Part B). Currently, the Trustees analyze the program as separate functions. Under the new law, if general revenue contributions exceed 45 percent of total Medicare spending, the Trustees will be required to alert the President and Congress.

These new accounting rules will provide greater transparency for the program when examining total obligations. However, effective cost containment will have to build upon this approach if the program's long-term solvency is to be maintained. Some lawmakers called for explicit Congressional action if general revenues were to exceed a certain threshold. That is a fair request – especially in light of the recent projection by the CBO that the cost of the drug benefit could increase to as much as $2 trillion in the second decade if Congress fills in the coverage gap under the new benefit, as already has been proposed by the Senate Democratic Leadership.[12]

While it proved impossible during last year's negotiations to fashion acceptable explicit mandates, additional corrective steps toward cost containment include indexing the new drug benefit premium

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[11]The Congressional Budget Office estimates that the Medicare legislation will increase federal spending by $395 billion over the next 10 years, but the real cost of the legislation could be much greater when viewed in terms of long-term, unfunded obligations. For instance, the FY 2004 Budget Resolution contained sobering news about the program's current unfunded promises – without a prescription drug benefit. Over the next 75 years, those obligations are projected to reach $13.3 trillion for total Medicare expenditures (Part A and B services combined). See Senate Report 108-19, p. 30.

[12]"Estimates on Medicare Hit $2 Trillion," *The Washington Times*, December 9, 2003. Reporting on comments made by Douglas Holtz-Eakin, CBO Director.

(currently estimated to be around $35 a month) to the costs of the program.[13] In addition, it applies new income thresholds for Medicare Part B premiums starting in 2007. The following thresholds apply:

- All beneficiaries with incomes below $80,000 (single) and $100,000 (couple) will see no change in their premium amount, and will continue to receive a 75-percent subsidy of such premiums by the federal government under current law.

- Beneficiaries with incomes between $80,000 and $100,00 (single) and $160,000 and $200,000 (couple) will receive a 65-percent subsidy and be required to pay 35 percent of the monthly premium.

- Beneficiaries with incomes between $100,000 and $150,000 (couple) and $200,000 and $300,000 (couple) will receive a 50-percent subsidy and pay 50 percent of the premium.

- Beneficiaries with incomes between $150,000 and $200,000 (single) and $300,000 and $400,000 (couple) will receive a 35-percent subsidy and pay 65 percent of the premium.

- Beneficiaries with incomes above $200,000 (single) and $400,000 (couple) will receive a 20-percent subsidy and pay 80 percent of the premium.

Furthermore, the legislation increases the Medicare Part B deductible from $100 to $110 in 2005. Thereafter, the deductible will be indexed to inflation. When the Medicare program was first established, the Part B deductible was set at $50. Over time, Congress passed legislation on three separate occasions, gradually increasing the deductible to $100; this amount has been current law since 1991. Unfortunately, the amount only represents 3 percent of current Part B expenses.[14] Indexing the Part B deductible to inflation will bring added fiscal responsibility to the program and eventually will reduce a portion of taxpayer burden.

In addition to these specific cost-containment tools, the Medicare legislation includes a new section to ensure consumers participate in decisions about their health care. The law takes an important step forward by establishing Health Savings Accounts (HSAs), formerly known as Medical Savings Accounts (MSAs), which will allow future beneficiaries to build sufficient resources over time to help pay for unexpected out-of-pocket medical expenses.

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[13]Beginning in 2006, the monthly beneficiary premium will be approximately $35. According to the Congressional Research Service (CRS), this amount represents, on average, 26 percent of the cost of the benefit provided. The premium will be adjusted up or down, as appropriate, to reflect differences between the cost of the benefit and the geographicallyadjusted national average monthly bid amount. It is further increased for any supplemental benefits and decreased if the individual is entitled to a low-income subsidy. CRS, "Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," December 9, 2003.

[14]"Medicare Prescription Drug, Improvement, and Modernization Act of 2003," Conference Report 108-391, p. 692.

Currently, employees do not pay income taxes on the health care benefits offered by their employers. This special tax treatment has led to a dominant employer-based health insurance system. The HSAs will allow individuals to be in greater control of their health care needs and take their coverage with them regardless of employment.

Some lawmakers argued that these accounts did not belong in the Medicare legislation, claiming that the bill was designed to provide prescription-drug coverage for Medicare beneficiaries – not expand a particular health tax policy for the uninsured. However, it is important to note that the original MSAs were scheduled to expire on December 31, 2003. In addition, these accounts needed a significant overhaul since such policies had been slow to gain market share due to restrictions imposed on eligibility, qualified deductions, and contributions. For instance, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 [P.L. 104-191] stipulated such accounts only would be available to employees of small businesses and the self-employed. Moreover, the law limited contributions to either an employer or individual. These contributions were capped at between $1,700 and $2,500 for self-only coverage and between $3,350 and $5,050 for family coverage.

Under the new Medicare law, HSAs will be permanent and available to all individuals. Also, both employers and individuals can contribute to the accounts, which can be as large as the individual's health insurance plan deductible – that is, between $1,000 and $5,000 for self-coverage and $2,000 and $10,000 for family coverage. These modifications will help the very people who, through their taxes, will be paying for the new drug benefit Medicare beneficiaries receive.

Conclusion

Over the past 30 years, the Medicare program has failed to incorporate many of today's health care advances that have been made available by private insurance, such as preventative medicine, disease management, and prescription-drug coverage. This new law finally incorporates these options into Medicare, and, in so doing, vastly modernizes and strengthens the program.

There is legitimate criticism that the legislation is too broad and, at the same time, does not accomplish enough. Given political realities, critics must recognize the congressional dynamics involved in shepherding a bill of such magnitude through a closely divided House and Senate. In that light, Republicans' progress in achieving their goals was significant.

Under the new law, drug coverage will remain voluntary. The cost of prescription drugs will decrease. The number of health care choices has been expanded. Health Savings Accounts will become commonplace. Finally, there is a potential through private-sector opportunities for the program to be fiscally stronger. These goals for Medicare modernization were achieved in significant measure, notwithstanding the many compromises that were required. The challenge for Republicans will be to protect these gains and continue the process of strengthening Medicare and enhancing the quality of, and choices for, health care for all Americans.